Reactions To War And Systemic Violence: Differentiating Distress From Mental Illness. When/Is Psychiatric Treatment Required?

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Refugee Mental Health Symposium:

Clare Pain MD
Mount Sinai Hospital, Toronto.
THE DISTINCTION BETWEEN MI AND DISTRESS?

DISTRESS is a normal human experience, emerges and persists in proportion to the external stressful situations. **And ends when the stressor remits**

Not a watered down version of a MI - Intensely stressful circumstances can lead to **very serious but non disordered psychological conditions**.

MENTAL ILLNESS: some **internal psychological or physiological defect** is responsible for causing or maintaining the condition... stressful social experience can cause mental disorders - something goes wrong with the internal functioning of the individual - **even when the stressor is removed**. E.g. cough (Rema Lapouse 1967)
Trauma stories: we just assume anyone who has been through this MUST have PTSD or some kind of permanent mental health condition....

A medical diagnosis suggests a medical treatment, by an expert, medications and exposure therapy = EBT.... It implies that PTSD is universal and context-independent. This medicalization of suffering infers all suffering is pathological, an illness or disease, and must be treated within a medical model...It obscures the political and economic causes.

Suffering is inevitable for human beings and traumatic experience ubiquitous – to heal we have always needed the institutions of society where meaning and culture is sequestered: schools for our children, mosques, temples, churches, synagogues, work, health care, sport, community centers, pubs...

Less “treatment” more assistance with rebuilding the infrastructure which houses the culture’s system of meanings. Summerfield
TRAUMA FOCUSED OR SYMPTOM FOCUSED

- **Symptoms or Triggers?** Uniforms, dogs, some smells, shouting, bright lights, fighting in hockey,

- **Your tone of voice** (remember you have the power), clear calm explanations, language, the “UN method” – respect and kindness, interest and clarity.

It’s the ordinary things in life that heal refugees – a positive hearing, learning English, a job/school, decent housing, friends, linking the old with the new....

Ensure you communicate with the refugee about any concerns you may have, ask what they think, ask the FD for a MH assessment only if the refugee agrees.
CONSIDER A REFERRAL TO A FAMILY DOCTOR IF:

- Symptoms? (range and extent and length of their presence?)
  - Suicidal ideas/plans
  - Frank psychotic symptoms
  - Significantly compromised function
- Is the stressor still present? Is distress reduced or does it persist?
- What is the stressor? Is it in the past or the present?
- Who is more vulnerable to mental illness?
This graph shows the loss of subjective emotional arousal for pleasant pictures when viewing a set of unpleasant, neutral, and pleasant pictures in male Bosnian refugees suffering from PTSD (posttraumatic stress disorder).

COMMON STRESSORS EXPERIENCED BY REFUGEES

- Pre-Migration Stress
- Migration Stress
- Post-Migration Stress and Culture Shock
  - Immigration Status
  - Acculturation
  - Employment/financial status changes
  - Communication Gaps - language
  - Gender role conflicts
  - Family Role Reversal
  - High Parental Expectations
  - Social Isolation
  - Racism, Prejudice, and Discrimination
Maritn Baro And CCVT – Trauma Cultures

- Circles of silence
- Circles of support

individual

family

society
EXAMPLES

- Rwandan woman and ESL
- Young man who couldn't cook
- Somali woman
Assess the refugee as thoroughly as you can...remembering not to jump to early diagnosis – grief can look like depression – anxiety can be mistaken for uncertainty – what looks like psychosis can be a cultural presentation of distress – trauma will be there but notice how and when it is spoken about. Show concern clearly and “formally”

We can find ourselves too “interested” or avoidant of the stories refugees share with us. Avoid either projection or the assumption that symptoms are signs of mental illness - focus instead on the person in front of you!

Refugees are the most resilient of people and have often had good and stable childhoods.
• New Canadians do well if they think most about their future and attend to their present (Beiser).

• Psychotherapy is a foreign notion to most refugees. They are usually clear about what they want from psychiatric, psychological services, although they may not say so immediately. Ask gently – they do not wish to alienate you and are unsure about making a request.

• They usually need clear, pragmatic help – an EEG, a letter to their boss, changing sponsors, sleep medications, what to wear for an interview etc.
WORKING WITH REFUGEES IN CANADA LESSONS LEARNED - III

• Do whatever you reasonably can to help solve the problem.

• Do whatever you can to facilitate function and optimize mood.

• All new Canadians will feel better as they learn English. Learning English is excellent psychological treatment and mental health prophylaxis:
  - they can then read the newspapers, make phone calls to services, talk to their children’s teacher, read food and medication packaging –
Attacked with machetes. Escape, barefoot, across the stony desert.


Now home is a tent. A daily handful of maize. And unquenchable hope.

It takes courage to be a refugee

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